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MH 500E
Revised 09/07/04

CONSENT FOR SERVICES

The undersigned client or responsible adult* consents to and authorizes mental health service by

_____
Name of Facility

These services may include psychological testing, psychotherapy/counseling, rehabilitation service, medication, case management, laboratory tests, diagnostic procedures, and other appropriate services. While these services may be delivered at different locations, services provided within the Los Angeles County mental health system will be coordinated by the staff of a single agency.

The undersigned understands:

1. He/she has the right to
   a. be informed of and participate in the selection of any of the above services to be provided;
   b. receive any of the above services without being required to receive other services from the Los Angeles County mental health system.
2. All of the above services are voluntary and he/she has the right to request a change in service provider (agency or staff) or service coordinator or withdraw this consent at any time.
3. Information from a client's service record relative to service delivery needs may be shared with any agency within the Los Angeles County mental health system (County-operated and contract) without obtaining the consent of the client.
4. To ensure treatment staff have available to them the most complete information about you when deciding on treatment appropriate to your needs and for quality of care, any information you disclose to staff which is determined by them to be important to your care, will be recorded in your clinical record.
5. All personnel of the agency, as a condition of their employment, annually sign an oath of confidentially which prohibits them from sharing client information except as allowed under Federal, State, and Department confidentiality laws, policies, and procedures. Information contained in a client's service records is available to personnel within this agency who have a clinical need to access the information.
6. All client names are entered into a computer-based Management Information System that identifies the program(s) that is (are) providing services to the client. This information is available without client consent to any representative of the Department's directly operated or contract service agency system.

_____	_____	_____
Signature of Client	Signature of Witness	Date
_____	_____	_____
Signature of Responsible Adult	Relationship to Client	Date

☐ Client is willing to accept services, but unwilling to sign the Consent.

☐ I have completed or have caused to be completed the Consent of Minor form for any client under the age of 18 signing without parental/guardian consent.

_____	_____
Staff Signature	Date

This consent was translated into _____ for the client and/or responsible adult.

A copy of this Consent ☐ was given ☐ declined on _____ by _____
Date Initial

*Responsible Adult = Guardian, Conservator, or Parent of Minor

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to who it pertains unless otherwise permitted by law.	**Name:** **MIS #:** **Agency:** **Prov. #:** **Los Angeles County – Department of Mental Health**

CONSENT FOR SERVICE